

American Indian Identity in Mental Health Services Utilization Data From a Rural Midwestern Sample

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The governing bodies for psychiatry, psychology, and social work all publicly support culturally competent mental health care and have called for increased awareness of the importance of racial, ethnic, and cultural identity in mental health treatment and outcomes. However, since 1960 the population of people identifying as American Indian in the United States has grown faster than can be explained by birth rates, raising questions about the personal meaning of identity for newly self-designated American Indians. For this research, interviews were conducted with 14 self-identified American Indian clients receiving rural mental health care services in the Midwest. The goal was to assess clients' cultural connection to their racial identity and to understand what impact their American Indian identity had on their mental health care experiences. A modified Consensual Qualitative Research (CQR) method was used to develop the interview protocol and code responses. Interview data revealed that clients primarily based their racial identity on family stories of an American Indian ancestor and the majority did not feel their identification as American Indian was relevant to their mental health care. Regardless of lack of cultural connection, participants often reported feeling personal pride associated with identifying as American Indian. Implications for both researchers collecting self-reported race data and for mental health practitioners who might serve self-identified American Indian clients are discussed.

Keywords: American Indian, identity, mental health

Most research still regards racial/ethnic identity as a dichotomous variable inherited from one's parents: One either is or is not American Indian. If you are American Indian, at least one of your parents was American Indian. However, as indicated in Table 1, since the 1960s the U.S. Census has shown a consistently greater increase in the American Indian population "than can be accounted for by deaths, births, immigration, and improvements in census coverage" (Council of Economic Advisers for the President's Initiative on Race, 1998, p. 4). This means that people who did not previously identify as American Indian, or whose parents did not identify on the Census as American Indian, are now reporting their racial identity as American Indian. Nagel (1995) has argued that this "ethnic switching," or change in identification, is partially the result of ongoing American Indian ethnic renewal resulting from greater political activism. But others question the extent of the cultural connection among these "new Indians," as Hitt (2005) described them. Worsnop (1992) noted that most of the population growth among new Indians occurred in Southern and Eastern states where original American Indian populations were either decimated by colonization or removed westward. This geographic paradox offers one hypothesis for the increase in new Indian

populations: Without significant contemporary American Indian populations where culturally identified American Indians are readily observable people may be more likely to base American Indian ethnic identification on distant genetic claims. Our research indicates that this phenomenon may also be present in the Midwestern states.

The increase in people identifying as American Indian raises questions about the validity of using categorical, self-report race data to make generalizable inferences about American Indian populations and intervention efficacy. In several studies examining the consistency of race data reporting the most variation was found among people identifying as American Indian. Kressin, Chang, Hendricks, and Kazis (2003) compared 3 years' worth of Veterans Affairs administrative medical files with the 1999 Large Health Survey of Veteran Enrollees. The authors found 84% of the participants in the Large Health survey who identified as American Indian were not listed as American Indian the majority of the time in their VA medical records. This disparity may be partially attributed to the fact that some VA administrative race data is determined by staff observation rather than self-report. McAlpine, Beebe, Davern, and Call (2007) compared two data sets containing self-reported race data: Minnesota's administrative Medicaid records and a separate survey of Minnesota Medicaid enrollees. On average they found that the two data sets contained matching race data 94% of the time. However, American Indian respondents had the lowest classification synchronicity of any racial group: "[O]f the individuals that the administrative data classify as American Indian, 15% reported another racial/ethnic group in their survey responses" (McAlpine et al., 2007, p. 2379).

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Table 1
Population Change Among American Indians (AIs) and Multiracial AI (MRAIs) in the United States

Census year	AI population (% of U.S. population)	MRAI population (% of U.S. population)	AI/MRAI population increase (%)	U.S. population increase (%)
1960	551,669 (.3)	—	—	—
1970	827,255 (.4)	—	49.95	13.32
1980	1,420,400 (.6)	—	71.7	11.48
1990	1,959,234 (.8)	—	37.94	9.78
2000	2,475,956 (.9)	1,643,345 (.6)	110.25	13.15
2010	2,932,248 (.9)	2,288,331 (.7)	26.73	9.71

Note. Data source: U.S. Census Bureau, 2002a; U.S. Census Bureau, 2002b; U.S. Census Bureau, 2011a.

In our own research we were struck by unexpected demographic results that led us to question what identifying as American Indian meant to research participants and how it impacted their experiences with mental health care. Data collection initially took place as part of an NIMH funded study examining disparities in treatment outcomes among White and Black clients at rural community mental health agencies (Larrison, Schoppelrey, Hack-Ritzo, and Korr, 2011). Participants were asked to complete surveys about their mental health symptoms and services three times over a 6-month period. Surveys were initially administered to 837 self-selected clients at 13 community mental health agencies throughout the Midwest. Participants were asked to identify their race from the following list: American Indian or Alaskan Native; Asian; Black or African American; White/Caucasian; Native Hawaiian or other Pacific Islander; Multiracial or other (specify).

While the 2010 U.S. Census Bureau (2011a) found that slightly less than 1% of the U.S. population identifies as American Indian and .7% identify as multiracial including American Indian, 3.2% of study participants ($n = 27$) reported that they were American Indian and an additional 3% ($n = 25$) identified as multiracial, including American Indian on the initial self-report demographic section. In addition to the unexpectedly high number of American Indian participants, there was noticeable fluctuation in self-report of race identification. Of the clients who initially identified as full or partially American Indian ($n = 52$), 75% completed a second measure and 56% completed a third measure. Of the 39 participants who completed a subsequent second or second and third measure, racial identification remained consistent across multiple measures for 28% of participants ($n = 11$). Another 28% ($n = 11$) of the participants maintained some level of identification as American Indian but fluctuated between identifying solely as American Indian or as multiracial American Indian, and 44% ($n = 17$) did not identify as American Indian or multiracial American Indian on subsequent surveys.

To better understand the meaning of American Indian racial identification for these clients and how identification as American Indian affected participants' perceptions of and engagement in mental health care, clients who identified as American Indian or multiracial including American Indian were invited to take part in semistructured interviews. We used an exploratory approach and inductive analysis to develop an a posteriori hypothesis. Because of the inconsistencies in identity reporting in this sample and the debate regarding New Indians' levels of cultural identification, we hypothesized that New Indian identity in the Midwest did not have a compelling impact on experiences in mental health services.

Method

We attempted to contact all 52 participants who initially identified as American Indian or multiracial including American Indian. Of those participants, 58% ($n = 30$), could not be reached, either because their telephone number no longer worked, they were not at the same address, or they did not respond to letters or phone calls requesting an interview. Six percent ($n = 3$) declined to participate, 6% ($n = 3$) stated they were not American Indian, 4% ($n = 2$) were not available at the time of the interviews, and 27% ($n = 14$) were interviewed.

Participants

A sample of 14 clients who initially identified as American Indian were interviewed. The majority of participants were female (79%) and on average 48 years old ($SD = 11$ years). When examining patterns of racial reporting 50% ($n = 7$) did not vary and either consistently identified as American Indian or repeatedly identified as multiracial including American Indian. Another 36% ($n = 5$) fluctuated between identifying as both American Indian and multiracial including American Indian, and 14% ($n = 2$) converted from identifying as American Indian to uni-racial, White and Black respectively. The participants had been receiving mental health services for approximately 5 years ($SD = 5.75$ years). Fifty percent ($n = 7$) were receiving treatment for depression or other mood disorders, 29% ($n = 4$) for schizophrenia, and the remaining three participants were each respectively diagnosed with bipolar disorder, anxiety disorder, and dual diagnosis substance abuse and mental illness. Participants had mean BASIS-24 scores of 1.58 ($SD = .65$), 1.55 ($SD = .69$), and 1.64 ($SD = .99$). These scores represent clinically significant but longitudinally stable levels of symptomology that are typical of people receiving services for chronic mental illness.

Researchers. Two members of the research team served as primary judges. The team included a female European American social work graduate student with experience working with American Indian populations and a male European American social work associate professor with no experience with American Indian populations. The external auditor was a male American Indian psychology associate professor. The auditor was selected because of his knowledge and expertise related to mental health care for American Indians.

Per CQR methodology, the primary judges discussed their assumptions and biases prior to creating the interview script and conducting the interviews in an effort to avoiding allowing unex-

amined beliefs to influence the research. Assumptions of team members included the belief that romanticizing of American Indian culture was influencing participants to identify as American Indian and that participants might be using self-identification as an American Indian, rather than as a person with a mental illness, to explain feelings of alienation they experienced in their communities.

Procedure

Setting. Participants were interviewed in their homes, which were located in eight communities in two states in the Midwest. The home communities were all considered rural, having a population of less than 50,000 people (U.S. Census Bureau, 2011b). Participants' home communities were generally located several hours from the nearest metropolitan center. Prior to the interview participants signed a participation consent form that had been approved by the University of Illinois' Institutional Review Board. The researchers reviewed the consent form with each participant before it was signed and provided an additional copy of the consent form for each participant to keep for future reference. The names associated with participant quotes are pseudonyms.

Participants were all receiving mental health care at their local community mental health agency (CMHA). In the participants' communities the sole source of public mental health care were the CMHAs. These CMHAs employed 99 staff on average ($SD = 84$) and in 1 year saw on average 2,506 unduplicated clients ($SD = 2,046$). In four of the communities there were no other providers of specialized mental health care, whether public or private, besides the CMHA. Because of the extremely limited availability of mental health services in rural areas and the distance to other specialized providers we can be assured that participants recruited from community mental health agencies provide a meaningful representation of people seeking mental health care in these rural communities.

Sample size. In their initial work establishing methodologies for Consensual Qualitative Research, Hill, Thompson, and Williams (1997) recommend a sample size between 8 and 15 participants so for this research a sample of 14 participants was recruited. Hill et al. (1997) recommended this sample size range so there is "a large enough sample so that researchers can determine whether findings apply to several people or are just representative of one or two people. Using much larger sample sizes is unrealistic because of the time involved in examining each case intensively and because additional cases typically add minimal new data" (p. 532). This recommendation is supported by Guest, Bunce, and Johnson's (2006) analysis of sample sizes that found that thematic saturation occurred "within the first 12 interviews, although basic elements for metathemes were present as early as six interviews" (p. 59).

Measures. The interview protocol consisted of 16 open-ended questions. The interviewers used prompts and follow-up questions to elicit detail and explanations when participants gave brief answers. The questions focused on three core themes. The first core theme was familial understanding and representation of American Indian identity. This included questions about racial identification of family members and how American Indian identity is exercised. (Did any of your parents or grandparents identify as American Indian? Do you ever gather with other American Indians?). The

second core theme was personal understanding of American Indian identity. These questions explored the meaning of American Indian identity for the clients in their current environment and interactions with others (How well would you say that you fit into/in with your family? friends? neighbors? therapeutic setting? How does being American Indian affect these relationships?). The final theme was interaction of American Indian identity and mental health care. This included questions about how American Indian identity influenced understanding of one's mental illness or interventions to treat it (Have you ever considered utilizing traditional American Indian healing practices in your mental health care? Do you know how to access such care?). All respondents completed the full interview protocol. Interviews ranged from 19 to 63 min and lasted 35 min on average. Interviews were audio recorded and transcribed.

Process. Per Hill et al. (1997) recommendation, the judges reviewed relevant literature in order to develop interview questions that built on previous research. Overall interview construction was influenced by Perry G. Horse's (2001) paradigm of Indian identity. Horse acknowledges that it is hard to develop a comprehensive identity paradigm that applies to the over 500 distinct American Indian tribes and cultures of the United States, especially considering the differences created by contemporary society:

For many American Indians cultural transmission occurs in the family environment. For others it does not. Most of those who live in urban areas must deal with geographical dislocation from the tribal homeland. And, of course, all are affected by the mass media, popular American culture, the Internet, American schooling, and peer pressure. Even those who live in their tribal homelands do not necessarily receive systematic cultural or language instruction in the home. (p. 103)

Despite these challenges Horse has identified five elements that influence most American Indians' identity and consciousness development: language skills, biological elements, a worldview influenced by cultural traditions, self-identification, and tribal registration. Rooted in these themes the judges developed an initial set of questions which they shared with the external auditor, who contributed additional questions and wording suggestions.

The judges used a modified CQR methodology to analyze the interviews. Because all interviews were conducted face-to-face and both primary judges were present for and participated in all the interviews the judges altered the CQR process slightly and did not wait for coding of the transcribed interviews to begin consensus discussions. Rather, immediately after each interview the primary judges discussed their observations and notes to develop domains (themes in interviews) and core ideas (the simplified essence of participant statements; Hill et al., 2005). This allowed the debate and consensus process to be constantly ongoing and domains to emerge and grow as the interviews progressed. At the end of data collection the judges discussed the domains and their observations with the auditor and integrated his feedback into analysis. To ensure the data had been analyzed thoroughly one of the judges coded the transcribed interviews using the already developed domain list. The judges then reviewed the coded transcripts together and agreed that the domain list was complete and organized the domains into categories. Domains and categories with meaningful frequencies are presented in Table 2 and discussed in the Results section.

Table 2
Domains, Categories, and Frequencies

Domains and categories	Frequencies
Characteristics of American Indians	
Black hair, high cheekbones, skin color	Typical
Comfort with nature/animals	Variant
Strong spirituality	Variant
American Indian cultural activities	
No participation in activities/ceremonies	Typical
Reading books about AI culture	Variant
Culturally based mental health treatment	
No use of traditional/cultural healing	General
Willingness to try if offered	Typical
Identification of family members	
Family generally identifies as AI	Typical
Family generally does not identify as AI	Variant
Impact of identity on mental health services	
Not important to mental health care	Typical
Perceived monetary/education benefits	Variant
Personal meaning of AI identity	
Pride	Typical
Being special or having special abilities	Variant
Concerns about prejudice	Variant
Tribal identification	
Cherokee	Typical
Unknown/Other	Variant

Note. General = appears in all 14 cases; typical = 7 to 13 cases; variant = 3 to 6 cases (Elliott, 1989, 1993 as cited in Hill, Thompson, and Williams, 1997, p. 551).

Results

Interview respondents generally only met two criteria of Horse’s Indian identity paradigm: reported biological elements and self-identification. Some respondents described limited engagement with cultural activities but it seems that the majority of participants reported that they were American Indian because they had been told they had American Indian ancestors and felt this was an interesting distinction.

Language Proficiency and Tribal Membership

None of the participants reported having any level of facility with an indigenous language and all confirmed they were not enrolled members of federally- or state-recognized tribal communities. There has been some suggestion that the increase in American Indian identification is linked to perceived monetary and educational benefits afforded enrolled tribal members (Ross & Carey, 2008). Three of the participants alluded to the possibility that they or their children could receive educational scholarships but this did not appear to be a driving reason to identify as American Indian.

You know if you have Indian they pay for your kid’s schooling and stuff like that . . . I think my kids probably want to know a lot more than I do . . . They’re really interested in their heritage. And I want to know where I come from. (Rebecca, female, 47 years old)

Worldview and Cultural Traditions

Almost all respondents stated they had never participated in American Indian cultural or religious activities. One respondent

recalled watching her father perform ceremonial dances as part of an American Indian themed Boy Scout program and another stated:

We built our own sweat lodge several years ago. We didn’t know the exact ritual but we made our own up. (Phil, male, 53 years old)

Though none of the participants had overt exposure to cultural experiences a few felt their worldview was none the less influenced by their American Indian identity.

But Indians believe in different entities a lot of times. Like some are sort of primitive in a way to where they would pray before they shot the deer or whatever they did with it with the bow hunting. It’s like they pray first. They thank it, you know what I mean? It’s like they had respect for it. And there’s a respect that I was brought up with like that somehow, it’s built in. I was taught that in a built in way, but it’s hard to explain. I’m so glad that I have that. Because I have a respect now of animals and of nature that I don’t think I would have had otherwise. (Vicky, female, 50 years old)

Biological Identification

Respondents’ discussion of the biological origin of their American Indian heritage was almost uniformly consistent: Twelve of the respondents stated they had grandparent(s) or, most commonly, great grandparent(s) who were American Indian, whom they frequently identified as Cherokee.

I have a great grandmother. She’s an Indian. She’s, I think she’s Cherokee. And my great grandfather is part another Indian tribe. They was already dead when I was alive. (Cheryl, female, 51 years old)

My great, not my great, well I guess it would be my great. My grandmother was Cherokee. I believe she was full blooded. Or at least that’s my understanding of what my aunt said and my momma said. There’s Indian on my father’s side, but I couldn’t say whether it was my grandmother that was full blooded or not. She was already gone before I was born. (Dora, female, 45 years old)

On the maternal side my great grandmother was full blooded Cherokee . . . On the paternal side my great grandfather was full blooded Cherokee and he married my great grandmother and she was three fourths Cherokee. And we have blood coming in from other marriages so the way I figure it I’m at least one third Cherokee. (Phil, male, 53 years old)

The exceptions were two participants who stated their fathers were American Indian. However, both respondents stated they had little or no contact with their fathers while growing up and had not discussed their cultural heritage with their fathers.

I was told Cree and DeSoto. [My maternal grandmother] didn’t know much. She said my father was full Indian, my mother was American, and I was half Indian. (Leslie, female, 21 years old)

Self-Identification

When interviewees were asked how they defined themselves as American Indian, responses often focused on stereotypical physical features associated with American Indians such as black hair, high cheekbones, and darker skin.

You can tell I'm an Indian by the way I talk and you can tell by my cheekbones. You can tell by my rough voice that I'm an Indian, can't you? (Albert, male, 59 years old)

[My mother's] mother really looked Indian. You could tell she was Indian . . . She had the long, braided, dark hair and you could just tell my granddaddy was too just by looking at him, the cheekbones. (Rose, female, 61 years old)

A few respondents also highlighted characteristics that set them apart from others as indicators of their Indianess.

It means I'm just different from the other people. That's all. I just don't act like other people. A lot of people are real loud and Indians aren't loud. (Sarah, female, 50 years old)

There's a lot of family members in my family have psychic ability. We feel that that goes back to the Indian side of the family. And my mom had a lot more, I have a little bit, but my mom had a lot. She could tell when someone was thinking about her. (Vicky, female, 50 years old)

Impact on Mental Health Treatment

Because these participants presented with a low level of cultural connection to their self-reported American Indian identity, we were curious as to how their identity would impact their perceptions of and experiences in mental health care. Ten of the participants stated that they had not told their mental health providers that they identified as American Indian. When questioned why they did not disclose their racial identity respondents were largely dismissive of the need to do so.

It didn't matter. To me it didn't matter. I didn't see anything different. (Sarah, female, 50 years old)

I haven't told them myself. It doesn't seem important. (Leslie, Female, 21 years old)

No. No I never thought of [telling my therapist I identify as American Indian]. (Agnes, female, 54 years old)

Among the four participants who had informed their mental health care providers that they identified as American Indian, there were differing reasons for doing so. Two respondents shared their identity with mental health providers because they felt it might be generally relevant.

They was asking this and asking that. I just brought that up too. I thought that might be some of my problem. No, I was just reaching for straws . . . Just trying to figure out something that would help. (Rose, female, 61 years old)

However, two of the participants felt their identification as American Indian was important to their self-definition and should be respected by providers as part of a positive therapist-client working alliance.

A lot of things I try to tell these people they just say, "Well, you're delusional. You don't know what you're talking about." But see they don't know. They only know what they see and what people have told them. They don't know nothing about me. They don't know where I've been or what I've done or nothing. (Kevin, male, 39 years old)

Actually, [my counselor], she's more open to, she's open to my beliefs. And without her open to my beliefs it would make an impact

on my mental health care. So it does make a big difference how I believe and how she views that. Like if she didn't believe it, then that would create a big gap in our communication. And I'm afraid that it would affect it so much that I'd probably either have to go to somebody else or someone that did believe in what I believe in. (Vicky, female, 50 years old)

Impact on Self-Concept

Though most participants did not feel their American Indian identity was relevant to their mental health care many did experience positive mental health benefits from their American Indian identity because they associated it with personal pride, strength, and connection to family.

Well, my brother was really proud of [being American Indian] and he's family and I'm a family person. So, it means a lot. Like I said, just knowing is enough for me. I don't care if you believe it. Who knows? I know. But just knowing it is a lot for me. (begins to cry). (Rebecca, female, 47 years old)

I think it's something to be proud of, to me. You know cause actually the Indians are the ones who founded this country. They were given a raw deal. (Rose, female, 61 years old)

I'm proud of it. It's just the generations of my family . . . Half of my family are Indians. (Gwen, female, 37 years old)

I take pride in being an Indian kid. I think it's wrong when you're a certain, have certain things in you and you want to deny it. You should never deny who you are. . . . I just think of [being Indian] as being interesting. It just makes me, me. (Dora, female, 45 years old)

I'm proud. Because my ancestors fought for this country. I'm proud to be American Indian. (Kevin, male, 39 years old)

It just makes you proud, being Indian. To have survived the things they went through. (Leslie, female, 21 years old)

Discussion

The number of people in the United States identifying as American Indian or multiracial including American Indian has risen faster than the birthrate for 50 years. An unusually large population of people identifying as American Indian and multiracial American Indian was also observed in a sample of community mental health clients in the Midwest. We conducted interviews with 14 chronically mentally ill participants who identified as American Indian. For this sample, interviews showed that participant American Indian identity was based on family oral history and self-selection. The majority of participants did not feel their racial identity was pertinent to their mental health care though they generally drew personal satisfaction from this status.

Implications

Mental health practitioners. The results of this study indicate that self-reported American Indian identity is not sufficient to recommend alternative or culturally based mental health interventions. Practitioners must pursue additional lines of questioning with clients in order to understand the salience of their racial identity. Though practitioners may find that racial identity is of limited relevance to mental health services for new Indian popu-

lations this does not mean that they should challenge this identity in situations where it is not clinically necessary. For two of the participants it was obvious that discussion of racial identity did impact their relationship to mental health service providers. One participant expressed anger that so many of his statements and beliefs were challenged and labeled as delusional: It is easy to understand how upsetting it would be to feel that no part of one's personal identity was free from "rehabilitation." For the other participant, the willingness of her provider to accept her world view strengthened the relationship: Respect for worldview and self are key to establishing and maintaining the therapeutic alliance. In addition, the interviews suggest that for practitioners utilizing a strengths based approach a clients' identity as American Indian may be a source of personal pride and strength that they can draw on to help them overcome obstacles and setbacks commonly experienced during mental illness. Though we do not suggest that practitioners disingenuously encourage clients to focus on or play up being American Indian it does appear that there is little to be gained and damage to be done by challenging a client's assertion that they identify as American Indian.

Mental health researchers. Most researchers using self-reported race data assume that racial identity is imbued with cultural meaning and lived experiences. These findings suggest that this cannot be assumed for all people identifying as American Indian. Had we adhered to self-identified racial categories in the initial study from which this sample was drawn we would have made, albeit unknowingly, inaccurate statements about mental health care disparities, treatment outcomes, and implications for American Indians' mental health care. This concern can be expected to become more of an issue if the number of people identifying as American Indian or multiracial continues to increase disproportionately. Categorical, self-report based data sets such as the U.S. Census, National Vital Statistics System, CDC WONDER, and Medicaid and Medicare databases are commonly used for research purposes and are vulnerable to this phenomenon.

Researchers focusing on American Indian populations must be aware of this issue and exercise caution. In studies where researchers hope to target American Indian participants it is necessary to consider how they are defining American Indian identity (Mihe-suah, 1998). Ma, Khan, Kang, Zalunardo, and Palepu (2007) reviewed every article published in four top medical journals from 1999–2003. They found that only "14% ($n = 159$) described how racial/ethnic categories were assigned" (p. 574). Of those that did provide such information only 19% provided further details such as if participants were offered predetermined categories or an open option that was later categorized. At minimum researchers must be clear about how they assigned membership to racial groups and what impact this may have on the interpretation of results.

In addition to stating how American Indian participants are identified, researchers should consider expanding standard racial checklists to include additional questions or ethnic/cultural scales to gauge the level of participant cultural identification. Examples of instruments that researchers can use to better describe cultural identity among American Indians include Moran, Fleming, Somervell, and Manson's (1999) Bicultural Ethnic Identity Scale, which evaluates adolescents' levels of identification with both Indian and mainstream White culture; the Native American Cultural Values and Beliefs Scale, which is a tool used to assess multiple dimensions of American Indian values and beliefs (Reynolds, Quevillon,

Boyd, & Mackey, 2006); or Winterowd, Montgomery, Stumbling-bear, Harless, and Hicks' (2008) American Indian Enculturation Scale, which assesses adherence to American Indian cultural values.

Practicing racial categorization transparency and using cultural identity measures will provide more accurate participant sample descriptions and help consumers of research literature to better understand and appropriately apply findings. These recommendations for American Indian-focused research mirror discussions around other racial categories: Agyemang, Bhopal, and Bruijn-zeels (2005) recommend retiring the term Black from research and utilizing the most specific descriptive terminology possible to indicate nationality, ethnicity, and distant versus recent African ancestry while Kibria (1998) has written extensively about the dilemma of a pan-Asian identity that glosses over nationality, immigration status, and acculturation/enculturation. These approaches will help ensure the clarity of findings and the validity of disparity analyses and intervention recommendations.

Limitations

The primary limitation of this study is the size of the sample and its geographic restrictions. Though the sample of 14 participants is within the recommended CQR sample size, as is common in qualitative research, this does affect the generalizability of the findings (Bailey, 2007). Our analysis focused on participants in rural areas of the Midwest. These findings may not be as relevant in areas of the country with reservations, tribal headquarters, or significant contemporary American Indian populations as people may be less likely to base American Indian ethnic identification on distant genetic claims if they reside in areas where larger numbers of culturally identified American Indians are readily observable. However, this limitation should be seen as an opportunity for further quantitative and qualitative research that explores the changing and developing meaning of categorical American Indian identification in varied geographic and population density settings.

Some readers may assume that propensity to identify as American Indian or report fluctuating racial identification is the result of impaired functioning because of mental illness. However, there is no evidence that mental illness in-and-of-itself leads to confusion about racial identity or changing racial identities (Mossakowski, 2003). The same trends identified in our sample are observable in large scale dataset that target the general population: In addition to the disproportionately rising American Indian populations in the U.S. Census, the National Longitudinal Study of Adolescents had nearly 12% within participant racial identification mismatch because of participants changing their racial identification report over time (Harris & Sim, 2002).

Conclusion

American Indians are the most regulated racial group in the United States: To be a member of a federally recognized tribe American Indians must prove their ancestry and in some cases be issued a Certificate of Degree of Indian Blood by the Bureau of Indian Affairs (Hamill, 2003). Yet this highly formalized approach to identity is rooted in White colonizer's arbitrary historical decisions about defining the other and decreeing who was American Indian. The changes in American Indian populations may reflect

the movement of American Indian identity toward the standard applied to all other racial categories: self-identification based off of each individual's personal criteria. However, our research demonstrates that care should be taken when estimating the relationship between self-identified race, cultural identity, and mental health services in the absence of data beyond a census type checked box. As discussed in the Implications section, researchers focusing on American Indian populations must recognize the unique and complicated history of defining American Indian identity and challenge themselves to move beyond simplistic categorizations. If not, they will risk presenting sterile findings that do not reflect the complex reality of contemporary American Indian identity.

References

- Agyemang, C., Bhopal, R., & Bruijnzeels, M. (2005). Negro, Black, Black African, African Caribbean, African American or what? Labelling African origin populations in the health arena in the 21st century. *Journal of Epidemiology and Community Health, 59*, 1014–1018. doi:10.1136/jech.2005.035964
- Bailey, C. A. (2007). *A guide to qualitative field research* (2nd ed.). Thousand Oaks, CA: Pine Forge Press.
- Council of Economic Advisers for the President's Initiative on Race. (1998). *Changing America: Indicators of social and economic well-being by race and Hispanic origin*. Retrieved from <http://www.gpoaccess.gov/eop/ca/pdfs/ca.pdf>
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*, 59–82. doi:10.1177/1525822X05279903
- Hamill, J. F. (2003). Show me your CDIB: Blood quantum and Indian identity among Indian people of Oklahoma. *American Behavioral Scientist, 47*, 267–282. doi:10.1177/0002764203256187
- Harris, D. R., & Sim, J. J. (2002). Who is multiracial? Assessing the complexity of lived race. *American Sociological Review, 67*, 614–627. doi:10.2307/3088948
- Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196–205. doi:10.1037/0022-0167.52.2.196
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25*, 517–572. doi:10.1177/0011000097254001
- Hitt, J. (2005). The newest Indians. *The New York Times Magazine, August 21*. Retrieved from <http://www.nytimes.com/2005/08/21/magazine/21NATIVE.html?pagewanted=all>
- Horse, P. G. (2001). Reflections on American Indian identity. In C. Wijeyesinghe & B. Jackson (Eds.), *New perspectives on racial identity development: A theoretical and practical anthology* (pp. 91–107). New York, NY: New York University Press.
- Kibria, N. (1998). The contested meanings of "Asian American": Racial dilemmas in the contemporary U.S. *Ethnic & Racial Studies, 21*, 939–958. doi:10.1080/014198798329739
- Kressin, N. R., Chang, B.-H., Hendricks, A., & Kazis, L. E. (2003). Agreement between administrative data and patients' self-reports of race/ethnicity. *American Journal of Public Health, 93*, 1734–1739. doi:10.2105/AJPH.93.10.1734
- Larrison, C. R., Schoppelrey, S. L., Hack-Ritzo, S., & Korr, W. S. (2011). Clinician factors related to outcome differences between black and white patients at CMHCs. *Psychiatric Services, 62*, 525–531. doi:10.1176/appi.ps.62.5.525
- Ma, I. W. Y., Khan, N. A., Kang, A., Zalunardo, N., & Palepu, A. (2007). Systematic review identified suboptimal reporting and use of race/ethnicity in general medical journals. *Journal of Clinical Epidemiology, 60*, 572–578. doi:10.1016/j.jclinepi.2006.11.009
- McAlpine, D. D., Beebe, T. J., Davern, M., & Call, K. T. (2007). Agreement between self-reported and administrative race and ethnicity data among Medicaid enrollees in Minnesota [Special Issue]. *Health Services Research, 6*, 2373–2388. doi:10.1111/j.1475-6773.2007.00771.x
- Mihsuah, D. A. (1998). American Indian identities: Issues of individual choices and development. *American Indian Culture and Research Journal, 22*, 193–226.
- Moran, J. R., Fleming, C. M., Somervell, P., & Manson, S. M. (1999). Measuring bicultural ethnic identity among American Indian adolescents: A factor analytic study. *Journal of Adolescent Research, 14*, 405–426. doi:10.1177/0743558499144002
- Mossakowski, K. N. (2003). Coping with perceived discrimination: Does ethnic identity protect mental health? *Journal of Health and Social Behavior, 44*, 318–331. doi:10.2307/1519782
- Nagel, J. (1995). American Indian ethnic renewal: Politics and the resurgence of identity. *American Sociological Review, 60*, 947–965. doi:10.2307/2096434
- Reynolds, W. R., Quevillon, R. P., Boyd, B., & Mackey, D. (2006). Initial development of a cultural values and beliefs scale among Dakota/Nakota/Lakota people: A pilot study. *American Indian and Alaska Native Mental Health Research, 13*, 70–93. doi:10.5820/aian.1303.2006.70
- Ross, J., & Carey, C. (2008). For payout or pride, more claim Native American heritage. *USA Today, September 9*. Retrieved from http://www.usatoday.com/news/nation/2008-09-11-nativeamerican_N.htm
- U.S. Census Bureau. (2002a). *The American Indian and Alaska Native population: 2000*. Retrieved from <http://www.census.gov/prod/2002pubs/c2kbr01-15.pdf>
- U.S. Census Bureau. (2002b). *United States: Race and Hispanic origin: 1790 to 1990*. Retrieved from <http://www.census.gov/population/www/documentation/twps0056/tab01.pdf>
- U.S. Census Bureau. (2011a). *Overview of race and Hispanic origin: 2010*. Retrieved from <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>
- U.S. Census Bureau. (2011b). *2010 Census urban and rural classification and urban area criteria*. Retrieved from <http://www.census.gov/geo/www/ua/2010Urbanruralclass.html>
- Winterowd, C., Montgomery, D., Stumblingbear, G., Harless, D., & Hicks, K. (2008). Development of the American Indian enculturation scale to assist counseling practice. *American Indian and Alaska Native Mental Health Research, 15*, 1–14. doi:10.5820/aian.1502.2008.1
- Worsnop, R. L. (1992). Native Americans. *CQ Researcher, 2*, 385–408.